

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042113

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10223

STATE FILE NUMBER

FILED OCT 31 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>5705 Cabanne Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edith Mae Taylor</b>		4. DATE OF DEATH Month Day Year <b>10 10 1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-15-27</b>
9. AGE (last birthday) <b>36 yrs.</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>David Snowden</b>		13b. MOTHER'S MAIDEN NAME <b>Aretta Saloney</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Aretta Saloney-5705 Cabanne Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Traumatic External Hemorrhage: Contrib:</b> <b>Deep Stab wound right side of neck, severing many vessels: suffered at the hands of party or parties unknown. Exact time and place could not be determined.</b> DUE TO (b) <b>Homicide</b> DUE TO (c) <b>Homicide</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>982x</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>See above</b>		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <b>10-10-63</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>St. Louis, Mo</b>	
20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>		20g. COUNTY <b>St. Louis</b>	
20h. STATE <b>Mo</b>		21. I attended the deceased from death occurred at <b>2:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>[Signature]</b>		22b. ADDRESS <b>1300 Clark</b>	
22c. DATE SIGNED <b>10-14-63</b>		23. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Louis (County) Missouri</b>		24. FUNERAL DIRECTOR ADDRESS <b>Ellis Funeral Home-2820 Stoddard St.</b>	
25. DATE RECD. BY LOCAL REG. <b>OCT 14 1963</b>		26. REGISTRAR'S SIGNATURE <b>Roal Smith. M.D.</b>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Arthur E. Calkin

Licensed Embalmer No. 4198

P. O. Address Alhambra 13 Mr

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.